JUNEAU COUNTY DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION FOR USE & DISCLOSURE OF CONFIDENTIAL INFORMATION

_____ _____ _____
Name of Individual/Previous Names Birth Date Social Security No.

Address: _____

AUTHORIZES:

Juneau County Department of Human Services

_____
Unit

220 E. LaCrosse Street – Rm. 23
Street Address

Mauston, WI 53948
City, State, Zip Code

(608) 847-2400 (608) 847-9421
Agency Phone Fax

TO EXCHANGE ☐ RELEASE TO☐ OR RECEIVE CONFIDENTIAL/PROTECTED HEALTH INFORMATION FROM:

_____
Individual/agency/organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone Fax

INFORMATION TO BE RELEASED: Information to be released may be in Written, Verbal, Voice Mail, Fax, or Electronic

☐Initial Assessment ☐Mental Health Records ☐Early Intervention Records/Birth To 3
☐Medications ☐Psychological Evaluation ☐Family & Safety Assessments
☐Progress Notes ☐Medical Records ☐Financial Information
☐AODA Records ☐Permanency Plans ☐Case Plans/Evaluations
☐Other (Specify):
Records to be disclosed are between the dates of _____ and _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐Continuity of Care ☐Further Medical Care ☐Insurance eligibility/Benefits
☐Educational Planning ☐Personal ☐Legal Investigation or Action
☐Changing Providers ☐Coordination of Services ☐Evaluate & Plan an Individualized Program
☐Other (Specify):

I HAVE REVIEWED AND UNDERSTAND MY RIGHTS, WHICH ARE PRINTED ON THE BACK OF THIS FORM.

_____ _____
Client Signature Date of Client or Authorized Signature

_____ _____
Other Authorized Signature* Witness Signature

*Legally authorized because client is: ☐Minor** ☐Incompetent ☐Unable to sign due to disability ☐Deceased
Legal Authority: ☐Parent of Minor ☐Legal Guardian/Representative ☐Spouse
**See explanation of Clients younger than 18 years old described above.

All person signing for release of records instead of the client must state their relationship to the client and have available proof of legal authority prior to the release of the records.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL

EXPIRATION DATE: This authorization is good until the following (date) _____, specific authorized action is completed or one year from the date signed, unless a written notice of revocation is submitted. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Juneau County Department of Human Services. The revocation will be effective immediately upon the Juneau County Department of Human Services' receipt of my written notice, except that the revocation will not have any effect on any action taken by the Juneau County Department of Human Services in reliance on this Authorization before the Juneau County Department of Human Services received written notice of revocation.

Action needed: ☐ Send Records ☐Send For Records ☐Send Authorization Only ☐No Action Needed.

Return completed form to: _____

Staff Name: _____

Original: Information Provider **Yellow Copy**: Information Requestor/Receiver **Pink Copy**: Client

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by Federal Register "42 C.F.R. Part II"; "45 C.F.R. Parts 160-164", Wis. Statutes 51.30; Wis. Statutes 146.81(2); and Chapter HFS 92 of the Wisconsin Administrative Code. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without specific written consent of the client or their legal representative.

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION – I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of services I receive at Juneau County Department of Human Services; except however, if my services at Juneau County Department of Human Services are for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Juneau County Department of Human Services may refuse to provide services to me if I do not sign this Authorization.

RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION – I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form.

RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED – I understand that I have a right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization form, except for records of medication and somatic treatment. This right may be denied by the treatment facility director, or designee, during the client's treatment under certain circumstances. I may arrange to inspect my health information or obtain copies of my health information by contacting Juneau County Department of Human Services.

A uniform and reasonable fee may be charged for a copy of the records, which fee may be reduced or waived in accordance with agency policy for those clients who show an inability to pay. Section 51.30(40(d), Wisconsin Statutes, and Sections HFS 92.03(3)(d), 92.05, and 92.06, Wisconsin Administrative Code.

Wisconsin Statues recognizes the need for informed consent in certain circumstances. The Authorization is limited to records, dated up to and including the date specified by the client on this form. A new Authorization will be necessary for releases of information on care provided after the date specified by the client.

All clients 18 years of age and older must sign for the release of their own health records, unless one or more of the following conditions apply:

a. Client is incompetent
b. Client is disabled and cannot sign the form
c. Client is deceased (the surviving spouse or legal representative must sign authorization releasing records of deceased client).

Clients younger than 18 year:

a. Treatment for drug and alcohol abuse: Information from a minor's alcohol or drug abuse treatment can only be released with the consent of both the minor and their parent, guardian, or person in the place of the parent, except that outpatient or detoxification services information can be disclosed with only the minor's consent as long as the minor is at least 12 years old.
b. Treatment for mental health issues: A minor who is 14 years or older can consent to release of information without the consent of their parent, guardian, or person in place of a parent, as long as they are capable of providing informed written consent.

I understand that once Juneau County Department of Human Services discloses my health information to the recipient, Juneau County Department of Human Services cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable Federal and State law governing the use and disclosure of my health information.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I hereby, knowingly and voluntarily, authorize the Juneau County Department of Human Services to use or disclose my health information in the manner described in this Authorization. I understand that additional information regarding the Juneau County Department of Human Services and the Juneau County Human Services Privacy Practices is included in Juneau County Department of Human Services' Notice of Privacy Practices.